

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15474

CERTIFICATE OF DEATH

15473

1. PLACE OF DEATH a. COUNTY <u>Howard</u>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u>		b. COUNTY <u>Howard</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bethany Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS <u>Bethany Lane</u>		13.1			
3. NAME OF DECEASED (Type or print) <u>Lillian V. Falter</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>8</u> Year <u>67</u>		5. SEX <u>F</u>		6. COLOR OR RACE <u>Wh</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. B. DATE OF BIRTH <u>1/25/03</u>		9. AGE (In years last birthday) <u>64</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telephone Operator</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Balto., Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Dirsey</u>		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-03-6178</u>		17. INFORMANT <u>Mrs. Audrey Waters</u> <u>Bethany Lane-Ellicott City, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4771</u> IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> DUE TO (b) <u>Chronic myocardial disease</u> DUE TO (c) <u>Arteriosclerotic Cardio-vascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>6 mos.</u> <u>10 yrs</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (1) (this hospital) attended the deceased from <u>1-26, 1960</u> , to <u>11-8, 1967</u> , that (1) (we) last saw the deceased alive on <u>11-7, 1967</u> , and that death occurred at <u>7:55 AM</u> , from causes and on the date stated above.		22a. SIGNATURE <u>Thomas G. Herbert</u>		22b. DATE SIGNED <u>11-8-67</u>		22c. PHYSICIAN'S NAME (Type) <u>Thomas Herbert, M.D.</u>	
22d. ADDRESS <u>44 Church Road, Ellicott City, Md.</u>		23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/10/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Balto., Md.</u>	
24. FUNERAL DIRECTOR <u>Witzke F. D. - 4101 Edmondson Ave.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 10 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY HOWARD b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKRIDGE c. LENGTH OF STAY IN 1b 13-1		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY HOWARD c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKRIDGE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6505 TIMBERVIEW DR.		d. STREET ADDRESS 6505 TIMBERVIEW DR.	
3. NAME OF DECEASED (Type or print) CORDELIA		4. DATE OF DEATH Month NOV. Day 6, Year 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-14-1878
9. AGE (In years last birthday) yrs. 89		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ed. Burton		14. MOTHER'S MAIDEN NAME Elizabeth Ann Simms	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address Mrs. Edna M. Shumate, 6505 Timberview Drive			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute cardiac failure DUE TO (b) cardiomyopathy DUE TO (c) conformities of age Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 1 day 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) hypertension		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour "a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/6 , 19 67 , to 4/6 , 19 67 , that (I) (we) last saw the deceased alive on 4/6 , 19 67 , and that death occurred at 10:30 PM , from causes and on the date stated above.			
22a. SIGNATURE Bruce Brumbaugh		22b. DATE SIGNED 11/9/67	
22c. PHYSICIAN'S NAME (Type) BRUCE BRUMBAUGH		22d. ADDRESS 5609 MAIN STREET 21227	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-10-1967	
23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore County, Maryland	
24. FUNERAL DIRECTOR HOWARD H. HUBBARD		25a. REC'D BY REGISTRAR NOV 8 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY HOWARD MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY HOWARD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b YEARS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Tridelphia Rd		d. STREET ADDRESS Tridelphia Rd	
3. NAME OF DECEASED (Type or print) Dorothy Anderson Knight		4. DATE OF DEATH Month November Day 28 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 18, 1908
9. AGE (In years last birthday) 59 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) R. Nurse	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Bernard Anderson		14. MOTHER'S MAIDEN NAME Jennie Stuart	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Mr. Edwin Knight		Address Ellicott City, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia DUE TO Adenocarcinoma of left ovary with ab- dominal metastases and ascites Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) dominal metastases and ascites (c) 9 months			INTERVAL BETWEEN ONSET AND DEATH 6 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) did not attended the deceased from Feb. 10 , 1967, to Novem 28, 1967 , that (I) we last saw the deceased alive on Nov. 27 1967 , and that death occurred at 4:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE Charles S. Whitaker		22b. DATE SIGNED Nov. 29, 1967	
22c. PHYSICIAN'S NAME (Type) Charles S. Whitaker, M.D.		22d. ADDRESS Clarksville, Md. 21029	
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 12-1-67	23c. NAME OF CEMETERY OR CREMATORY LOUDEN PARK	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Harry W. Haight		25a. REC'D BY REGISTRAR Clarksville, Md.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE DEC 4 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Woodbine</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Woodbine</u>	
c. LENGTH OF STAY IN lb <u>Life</u>		d. STREET ADDRESS <u>Rt. 144</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 144</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Rachel</u> First <u>Alinda</u> Middle <u>Musgrove</u> Last		4. DATE OF DEATH <u>Nov</u> Month <u>13</u> Day <u>1967</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 28, 1895</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Samuel Reed</u>		14. MOTHER'S MARDEN NAME <u>Matilda Liddard</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mrs. Catherine Miles - Woodbine, Md.</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Sealed Myocardial Infarct</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Robert Thomas</u> M.D.		22. DATE SIGNED <u>Nov. 13, 1967</u>	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11-16-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Montgomery Chapel</u>	23d. LOCATION (City or Town) (County) (State) <u>Montgomery Co. Md.</u>
24. FUNERAL DIRECTOR <u>Harry W. Haight</u> <u>Lisecville, Md.</u> ADDRESS		25a. REC'D BY REGISTRAR <u>NOV 16 1967</u> DATE 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

Dear Sir,
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the matter of the ...
and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.
Very respectfully,
Your obedient servant,
J. H. Smith

x

Very truly yours,
J. H. Smith

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15477

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 44 Old Annapolis Rd.				d. STREET ADDRESS 44 Old Annapolis Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Eleanor Middle C Last Nelson				4. DATE OF DEATH Month November Day 2 Year 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/12/88		9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor-retired		10b. KIND OF BUSINESS OR INDUSTRY Dept. Pub. Welfare		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Nelson				14. MOTHER'S MAIDEN NAME Eleanor Cuddy			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 220-44-5634		17. INFORMANT Miss Mary Belle Nelson Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 334X IMMEDIATE CAUSE (a) Cerebral artery disease. DUE TO (b) arteriosclerosis and pericarditis of undiagnosed 2 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) fever.						INTERVAL BETWEEN ONSET AND DEATH 2 mon	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1966 , 19 Nov 2 , 19 67 , that (I) (we) last saw the deceased alive on 12:01 AM 19 67 , and that death occurred at Nov 2 M, from causes and on the date stated above.							
22a. SIGNATURE Robert B. Taylor				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Nov 3, 1967	
22c. PHYSICIAN'S NAME (Type) Dr. Robert Taylor				22d. ADDRESS 111 Colombia Rd.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/4/67		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Md.	
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229				25a. REC'D BY REGISTRAR DATE NOV 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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Dear Sir,
I have the pleasure to acknowledge the receipt of your letter of the 14th inst. in relation to the above matter.
The same has been forwarded to the proper authorities for their consideration.
Very respectfully,
[Signature]

[Faint, illegible text block]

Very truly yours,
[Signature]

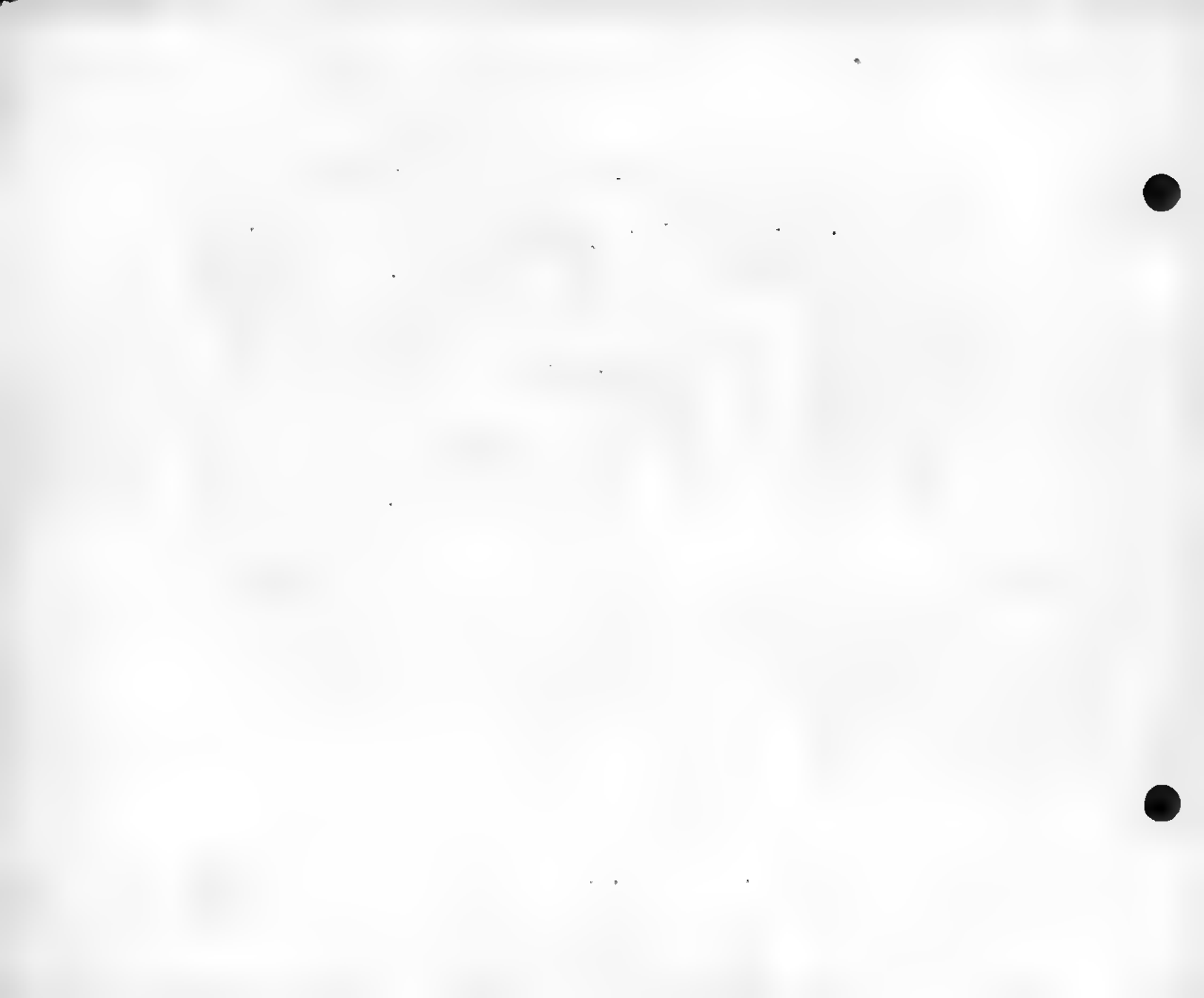
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

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FOR STATE HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Howard b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster c. LENGTH OF STAY N 1b Passing through d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp to, give street address) Balto. Nat. Pike 1 1/2 miles W. of Howard		2 USUAL RESIDENCE (Where deceased lived, if institution Res. before admision) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville d. STREET ADDRESS 205 Brightside Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) WILLIAM WATSON PAPE SR.		4 DATE OF DEATH Month November Day 7 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 AGE (In years last birthday) 66 yrs
10a. USUA. OCCUPAT. ON (Give kind of work done during most of workng life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Self-employed	
11 BIRTHPLACE (State or foreign country) Pikesville, Md.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Charles S. Pape		14 MOTHER'S MAIDEN NAME Mary West	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) None		16 SOCIAL SECURITY NO 212-12-7550	
17 INFORMANT Mrs. Grace W. Pape		Address 205 Brightside Ave.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxia Hypertensive/ Cardiovascular Disease/ 891.5 DUE TO (b) Carbon monoxide poisoning Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) While in car			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) While in car	
20c. TIME OF INJURY Month Day Year 10 pm Nov 7 1967	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home farm factory, street, office bldg., etc.) Road	20f. (City or town) (County) (State) near West Friendship Howard Md
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward F. Wilson		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Edward F. Wilson, M.D.		22. DATE SIGNED November 8, 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov. 14 1967	23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	23d. LOCATION (City or town) (County) (State) Woodlawn, Baltimore, Md.
24. FUNERAL DIRECTOR Frank H. Newell		25a. RECEIVED BY REGISTRAR NOV 14 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
3500 4-64

FOR STATE
HEALTH DEPT.

1
15480
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

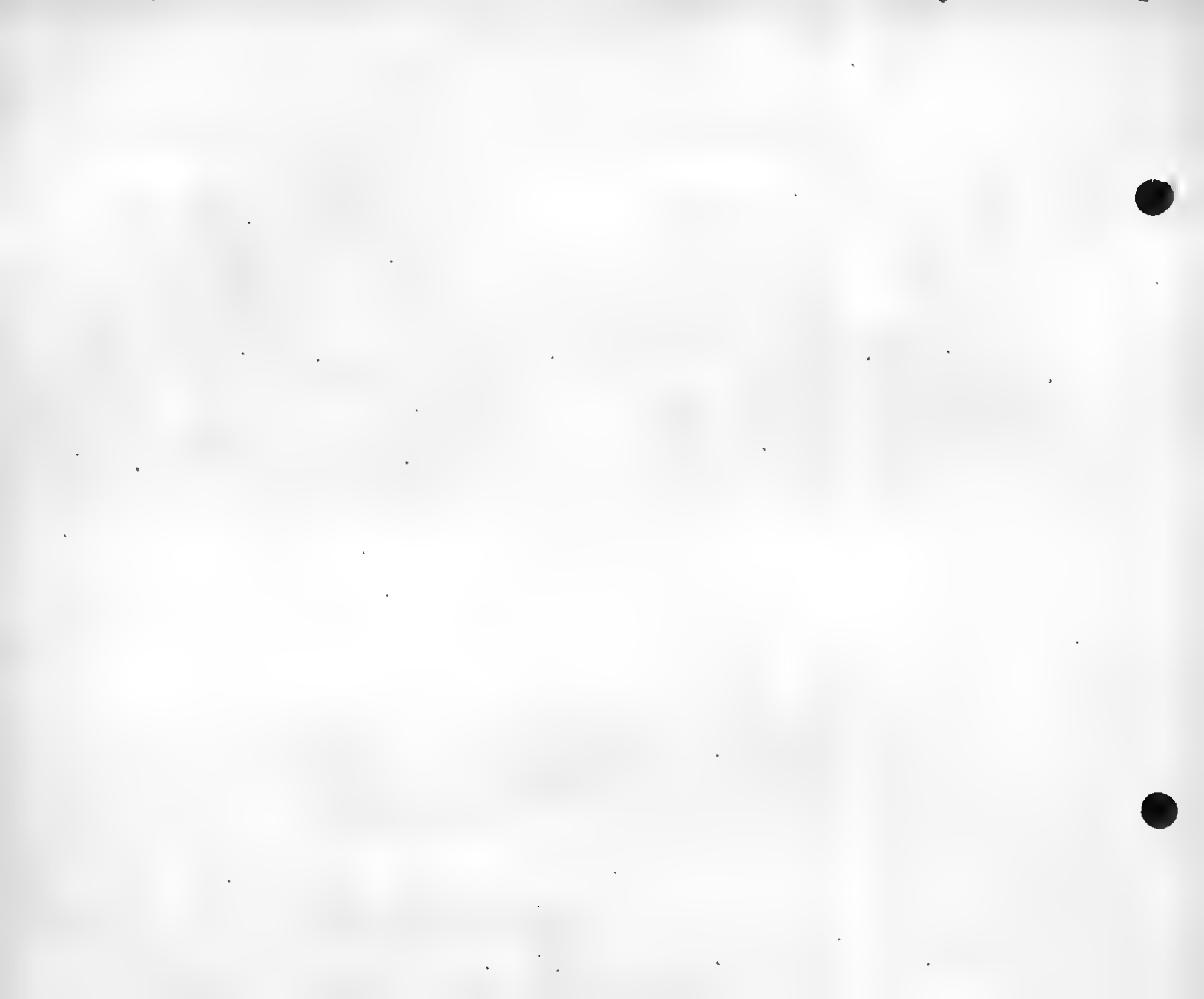
1. PLACE OF DEATH a. COUNTY Howard b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodbine c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Florence Rd.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodbine d. STREET ADDRESS Florence Rd. e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES LEROY PHEBUS		4. DATE OF DEATH Month November Day 11 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/31/30
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newspaper		10b. KIND OF BUSINESS OR INDUSTRY Route salesman	9. AGE (In years last birthday) 37 yrs. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS.: Hours <input type="checkbox"/> Min. <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Roy E. Phebus		14. MOTHER'S MAIDEN NAME Annie V. Warfield	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 215 26 1000	
17. INFORMANT Annie V. Phebus		Address Woodbine Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Self-inflicted shotgun wound of heart Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH instant.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Self-inflicted by shotgun	
20c. TIME OF INJURY Month, Day, Year 11.15 p.m. 11/11/67	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Woodbine, Howard, Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Whitaker		22. DATE SIGNED 11/12/67	
EXAMINER'S NAME (Type) Charles S. Whitaker, M.D.		Address (Street, city, town, or county) Clarksville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/14/67	23c. NAME OF CEMETERY OR CREMATORY Popular Springs	23d. LOCATION (City, town or county) (State) Popular Springs, Md.
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.		25a. REC'D BY REGISTRAR NOV 14 1967 DATE	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
15281 CERTIFICATE OF DEATH 15281

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE MD b. COUNTY PR. GEO.			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LAUREL				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LAUREL			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) RT 1 BOX 290 HARDING ROAD				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle GRAFTON Last RHODES				4. DATE OF DEATH Month NOV Day 17 Year 1967			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/23/1910	
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 5 Days 17 Hours 19 Min.		11. BIRTHPLACE (County & State, or foreign country) WASHINGTON Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOREMAN				10b. KIND OF BUSINESS OR INDUSTRY GASK ELEC CO			
13. FATHER'S NAME JOHN C. RHODES				14. MOTHER'S MAIDEN NAME SUSAN WILEY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.			
17. INFORMANT GLORIA E. RHODES				Address LAUREL MD, RT 1 BOX 290 HARDING RD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) Coronary Arteriosclerosis DUE TO (c) Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 hr 5 yr 10 yr							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/1 , 19 57 , to 11/17 , 19 67 , that (I) (we) last saw the deceased alive on 11/16 , 19 67 , and that death occurred at 3:37 PM , from the causes and on the date stated above.							
22a. SIGNATURE J. M. Warren				22b. DATE SIGNED 11/17/67			
22c. PHYSICIAN'S NAME (Type) J. M. WARREN				22d. ADDRESS Laurel Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF NOV 21 1967		23c. NAME OF CEMETERY OR CREMATORY GREENLAWN CEM.		23d. LOCATION (City, town or county) (State) WILLIAMSBURG, MD	
24. FUNERAL DIRECTOR John J. Hall				25a. REC'D BY REGISTRAR NOV 22 1967			
25b. REGISTRAR'S SIGNATURE 530 WASHINGTON AVE							



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15482

15481

1 PLACE OF DEATH a. Howard MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if not institution. Residence before admission) a. Maryland b. Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN IT Rural Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Shaffer's Convalescent Retreat, Inc		d. STREET ADDRESS 3507 Hillsmere Rd. 21207	
3. NAME OF DECEASED (Type or print) Clara Belle Rutter		4. DATE OF DEATH Month November Day 8 Year 67	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Dec. 8, 1886
9 AGE (in years) 80		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James K. S. Kemp		14. MOTHER'S MAIDEN NAME Isabelle G. Muir	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Charles Kemp Rutter		Address 3507 Hillsmere Rd. Balto Md 21207	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerotic cardiovascular disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 3 hrs. 10 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from February, 1966 to November, 1967 , that (I) (we) last saw the deceased alive on October 25, 1967 , and that death occurred at 10:30 P.M. from causes and on the date stated above			
22a. SIGNATURE <i>Millard T. Traband Jr.</i>		22b. DATE SIGNED 11/10/67	
22c. PHYSICIAN'S NAME (Type) Dr. Millard T. Traband, Jr.		22d. ADDRESS 1811 N. Rolling Road Balto Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/11/67	23c. NAME OF CEMETERY OR CREMATORY London Park	23d. LOCATION (City or Town) (County) (State) Balti. - Ind
24. FUNERAL DIRECTOR Living Byers		25a. REC'D BY REGISTRAR DATE NOV 14 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file them with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
15483		15482	
CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Mt. Airy		c. LENGTH OF STAY IN lb 13.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.F.D. # 3		d. STREET ADDRESS R.F.D. # 3	
3. NAME OF DECEASED (Type or print) First Willard Middle Ray Last Smith		4. DATE OF DEATH Month November Day 29 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 20, 1893
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 29 Days 13 Hours 1 Min. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own farm	
11. BIRTHPLACE (County & State, or foreign country) Mt. Airy, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David W. Smith		14. MOTHER'S MAIDEN NAME Alice V. Day	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-09-9030	
17. INFORMANT Mrs Alice M. Smith,		Address Item 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO (b) Atherosclerotic cardiovascular disease DUE TO (c) Diabetes mellitus		INTERVAL BETWEEN ONSET AND DEATH 1 hour 5 years 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 260x			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from October 5, 1967 to Nov. 29, 1967 that (I) (we) last saw the deceased alive on Nov. 29, 1967 , and that death occurred at 12:10 AM from causes and on the date stated above.			
22a. SIGNATURE James P. Kerr		22b. DATE SIGNED 11/30/67	
22c. PHYSICIAN'S NAME (Type) James P. Kerr, M.D.		22d. ADDRESS Damascus, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 1, 1967	23c. NAME OF CEMETERY OR CREMATORY Pine Grove	23d. LOCATION (City or Town) (County) (State) Mt. Airy, Md.
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.		25a. REC'D BY REGISTRAR DEC 5 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15484

17104

1. PLACE OF DEATH a. COUNTY HOWARD MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD, b. COUNTY HOWARD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Jessup			c. LENGTH OF STAY IN 1b 8 months			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Jessup	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 86 A Carroll Heights Ave.				d. STREET ADDRESS Box 86 Carroll Heights Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Louise Middle Hebron Last Wood				4. DATE OF DEATH Month 11 Day 30 Year 67			
5. SEX F	6. COLOR OR RACE G	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-6-1876		9. AGE (In years last birthday) yrs. 91	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME Isaac Atkins			14. MOTHER'S MAIDEN NAME Marsha Robinson				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			16. SOCIAL SECURITY NO. ?		17. INFORMANT Jessup Address Box 86 A Carroll Heights Ave Nettie Taylor		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Cerebral Hemorrhage Arteriosclerotic Vascular Disease with Hypertension 5 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ INTERVAL BETWEEN DEATH AND EXAMINATION _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE George E. Burgtorf M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22. DATE SIGNED 11-30-67	
EXAMINER'S NAME (Type) GEORGE E. BURGTORF M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
			Address (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 12-3-67		23c. NAME OF CEMETERY OR CREMATORY CARVER		23d. LOCATION (City or Town) (County) (State) CASH BLVD LAUREL MD	
24. FUNERAL DIRECTOR WILLIAM T. MOTEN				ADDRESS 2718-12 ST. N.E.		25a. REC'D BY REGISTRAR DEC 8 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

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Source: Young, 1994, p. 10.

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For

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Figure 1